401. Reference RFP Section H-1.b.(2)(c) - Has the government considered that this provision can encourage contractor gaming if the contractor's region has lower cost trends than will be experienced nationally? Likewise, a contractor can be hurt if the government does not accept reasonable regional trends that are higher than the national average. Will the government provide criteria/processes that will govern the negotiation to ensure that neither the government nor the contractor is unfairly advantaged?

RESPONSE: The Government will not pre-establish criteria as negotiations are best accomplished in an atmosphere which encourages consideration of all applicable factors. Although both contractors and the Government can estimate what national and regional trends will be, the actual numbers will not be known until a significant time after the period ends. Ideally the use of the national trend will not be required, and a negotiated position can be agreed upon prior to the start of each option period. During negotiations the Government will consider relevant regional factors and expects that contractors will do the same. The Government will, and expects the contractors to negotiate in good faith.

402. Reference RFP Section H-1.b (5)(b). - MTFs will have their own funds to purchase care in the civilian community. However, these purchases count against the contractor's actual healthcare costs. If MTFs do less and buy more services, the contractor will likely be harmed. Does the government contemplate another kind of adjustment that would compensate contractors for this factor that is beyond contractor control (especially important given the decreasing capabilities of many MTFs)?

RESPONSE: No, the annual adjustment is more than sufficient to account for any increases or decreases in MTF capability and capacity.

403. Section H.4.c of the RFP allows active duty and Medicare eligibles to consume some or all of the investment in RS without reduction of actual health care costs. Can the government provide experience detail on AD and beneficiary use of RS services and describe protections the contractor will have if this utilization increases significantly?

RESPONSE: The information available is included in the data tapes available for purchase by interested parties. The contractor's protection, as well as the Government's, is threefold: annual negotiation of target cost; 80-20 sharing in fee determination; and resource sharing agreements must be jointly approved by the government and the contract.

404. When TRICARE for Life was implemented contractors were deluged with calls from members with questions about the new benefit. It was impossible to predict the volume of calls and service suffered. Will the government allow change order costs to compensate the contractor for any penalties that might be incurred when the deterioration of service is due to government changes or actions?

RESPONSE: The Government will not access performance guarantees when the deterioration of services is determined by the Contracting Officer to be caused by the actions of the agency. As with TFL, program changes will be implemented through the change order process. This excludes routine changes in reimbursement rates and changes in the practice of medicine contained in RFP Section H-6.

405. Reference Sections H-5.d; and Attachment L-3 of the RFP - how will the Government ensure that only underwritten healthcare costs will be used to audit when non-underwritten healthcare costs will also exist in its claims database?

RESPONSE: Non-underwritten healthcare costs will be excluded from the annual health care cost audit. The Government will ensure the non-underwritten healthcare costs are excluded from this audit based upon the ASAP Bank Account number indicated in the voucher header information.

406. Reference Section H-1 of the RFP - please clarify the meaning/difference between "target healthcare cost" and "underwritten healthcare cost?"

RESPONSE: Target cost is a term used in incentive contracts, IAW FAR 16.4. Actual cost when compared to the target determines the resulting adjustment to the target profit or fee in accordance with the profit or fee adjustment formula. "Target health care cost", as used in this RFP, refers to the cost which will be compared to the actual "underwritten health care cost" to determine adjustment to the target underwriting fee in accordance with the fee-adjustment formula.

407. Reference Section H-1.b.(5)(e) of the RFP - please identify how much capitated cost currently exists by existing Region that cannot be handled in this manner as part of this solicitation. The bidder assumes that these capitated costs will be replaced by paid claims.

RESPONSE: No capitated costs in the existing regions are in effect. When they were, they were handled through the HCSR submissions.

408. In Section G-3 a.(1)(b)[2] of the RFP contractors are allowed to withdraw funds directly from the Federal Reserve for non-underwritten benefit payments. This is usually accomplished through the use of a letter of credit. We have interpreted non-underwritten benefit payments as meaning not at-risk payments. Section G-3 b.(2)(a) states that contractors will not disburse payments from not at-risk bank accounts. Could the government clarify intent on how not at-risk payments are to be made?

RESPONSE: G-3a relates to payments made or controlled by TMA-Aurora. Non-underwritten (not-at-risk) claims other than those paid by MTFs through DFAS as described in G-b. will be paid from the non-underwritten (not-at-risk) bank accounts as described in G-3a and TOM Chapter 3. G-3b only relates to payments that will be made by the MTFs. Claims paid by MTFs through DFAS will not be made from the non-underwritten bank account but will be billed to the MTFs and paid by DFAS. Also, G-3b will be clarified on the next amendment.

Note the term "letter of credit" should no longer be used. It is an old Treasury system that is no longer active.

409. Section G-5 of the RFP indicates eligibles will be computed using an average of six of the seven previous months. Will this be the six highest counts, six lowest counts or some other combination? Could the government clarify?

RESPONSE: An example may best explain the Government's intent. If the 7-month period is January through July, the Government will use the date in the monthly DEERS reports for January through June. July is necessary to receive the June

report and compute the average. The next six-month period will be July through December; however, the seventh month will be January.

410. Section H-5.e of the RFP states that contractors will not be reimbursed for securing refunds, rebates and credits. FAR 52.216-7 (h) 2 clearly permits treatment of these costs as allowable. Increasing the level of credits, rebates and credits would benefit both the contractor and the government through reduced health care costs. Could the government explain why the costs to increase these items are unallowable?

RESPONSE: H-5 and FAR 52.216-7 is only applicable to the cost-reimbursable part of the RFP, with exception to the case management/disease management line items as stated in H-5a. This only means that such costs are not, and will not be, allowable costs only under the health care line items, which are cost-reimbursable line items. Since this type of effort is not underwritten health care costs, it is considered an administrative cost.

411. Section H-6.a of the RFP states "the contractor underwrites all costs of all drugs covered under this contract." We believe this to be incorrect. Section C-7.42 indicates that pharmacy costs are not the responsibility of the contractor. Please clarify.

RESPONSE: The Health Care Contractor is to provide coverage for medications that are administered or consumed during an inpatient stay, as part of a clinic or outpatient procedure, or as a component of home health care services, to include home infusion services, or medications that are dispensed by physician or provider when that provider lacks a pharmacy identifier from the National Council for Prescription Drug Programs (NCPDP).

Coverage of medications by the Health Care Contractor in these situations must be provided as a component of services under the covered benefit. The Health Care Contractor is not responsible for outpatient prescription coverage from one of the four primary outpatient pharmacy sources: the direct care system, the TRICARE retail pharmacy network, the TRICARE Mail Order Pharmacy Program, or non-network retail pharmacies. This includes discharge medications prescribed for use outside the hospital, even though prescribed and obtained while still a registered inpatient, when those medications are obtained through one of the four outpatient pharmacy sources.

412. Section L.12.b of the RFP requires that a proposed subcontracting plan be submitted with the proposal. It further states that a final plan will be negotiated between the parties prior to award. Does this mean that the government will announce a winner and will then require the contractor to conclude subcontracting agreements? How long will contractors have to complete the agreements?

RESPONSE: Offerors are expected to provide a fully compliant subcontracting plan with their written proposal as stated in L-15. The statement, “A final plan will be negotiated between the parties prior to award”, gives offerors and/or the apparent awardees the chance to make the subcontracting plan acceptable to the Contracting Officer before contract award. The Government intends to announce a “winner” at the same time as the award is made.

413. Section L.12.e.(4) of the RFP requires the contractor to specifically state the

percentage of current primary care and providers that will continue to be network providers following the start of health care delivery. Will the government provide a file of network providers for all current contracts so that a comparison can be completed?

RESPONSE: Revised September 26, 2002
RESPONSE: The government will provide the provider directories.

414. Section L.12.f.(2)(a) of the RFP requires the contractor to submit past performance information 30 days prior to the proposal due date. Later the government requires that the past performance references be signed no earlier than 60 days from proposal submission date. This leaves only a 30-day window for signature. In order to maintain good customer relations, contractors do not want to impose on customers to complete signatures more than once. If the government delays the submission date, will the government allow references signed within 60 days of the initial submission date?

RESPONSE: This is a reasonable request and acceptable**.**

415. In Section L.14 of the RFP, the government requires bidders to include the administrative price of resource sharing in their administrative bid. Will the government provide current volumes of resource sharing initiatives so that a contractor can assess the administrative costs they are likely to incur?

RESPONSE: Available data was provided in the Amendment 2

416. In Section B of the RFP, in light of the Department's decisions to separate some current TRICARE programs into separate, stand alone contracts, could you please clarify the types of claims that are included in the estimated volumes of electronic and paper claims cited in the RFP? (For example, are Senior Pharmacy claims included? Dual eligible claims? Retail pharmacy? Etc.)

RESPONSE: Senior Pharmacy, CONUS dual eligibles, and retail pharmacy claim data are not included in the data package. The claims volume estimates represent only those claims expected to be processed by the MCSC.

417. Section F.4.a of the RFP includes the Fort Campbell catchment area of Tennessee in the Managed Care Support (MCS) North contract area. However, historical MTF and civilian referral patterns in this vicinity have typically been to the Nashville, TN area, which is included in the MCS South contract. To avoid complexity for TRICARE beneficiaries and for the MTF (inherent in trying to interface with two separate managed care support contractors, would the Government consider moving the Fort Campbell catchment area of Tennessee to the MCS South contract area?

RESPONSE: Thank you for your suggestion. We have elected to maintain the boundaries of the current regions, when merged to form the T-Nex regions.

418. Reference Sections C-7.1.5; C-7.1.9; C-7.1.16; C-7.1.16; C-7.2; C-7.3; C-7.3.1; C-7.3.2; C-7.12.1; C-7.16; C-7.17; C-7.30; C-7.30.1; C-7.31; C-7.37.1; and C-7.39 of the RFP - please verify that all references, currently and in the future, to MTF and to MTF Commander refer only to those locations or individuals supporting Inpatient Military Treatment Facilities as designated by the Catchment Area Directory (CAD).

RESPONSE: No, the reference refers to the individual in charge of all MTFs regardless of their inpatient capability.

419. Is Chapter 5 - MHS Referral and Authorization System, which is part of the TRICARE Systems Manual 7950.1-M issued August 1, 2002, a new requirement? If not, where does it currently exist in the former TRICARE Manuals?

RESPONSE: It is a new requirement.

420. Reference Section L.12.e.(4)(b) of the RFP - the claims information available on the data tapes ends with 09/30/01. Subsequent to this date, the enriched benefits (i.e., reduced catastrophic caps, TSRX, TFL, etc.) have caused various Active Duty Dependents and Non-Active Duty Dependents to rethink the value of the TRICARE Program. What is the Government's estimate of the cost increase that can be expected from these actions?

RESPONSE: Most NDAA 01 requirements were initiated by April 1, 2002. In order to capture the first 5 months of these activities, the Government will reissue the detail data tapes on or about September 16, 20002. The Government will not be providing cost estimates.

421. Reference Sections L.12.f.(4)(h)(3) and Attachment L-8 of the RFP - after excluding TRICARE for Life and TRICARE Senior Pharmacy claims, what is the EMC number and percentage of claims by existing Region for the most recent year under the current MCS Contracts?

RESPONSE: In response to this question, we have posted on the website the requested FY01 electronic claims data. The collection period for this FY01 report was 23 months (October 2000 - August 2002). Only initial claims were included (the report excludes adjustments and cancellations). Pharmacy, Senior Pharmacy, Foreign, Puerto Rico claims were also excluded.

422. In Section B of the RFP, estimated Option Year 1 paper claims per Section B is 9,550,442. This appears to be a typo since Attachment L-8 lists 955,044 paper claims for the same period. Option Year 2 paper claims per Schedule B are 2,003,397. Could you please clarify.

RESPONSE: This was revised in Amendment 0001.

423. Attachment L-1 states that the MCSC is "at-risk" for the cost of all care and services provided to PRIME enrollees with civilian PCM, TRICARE extra and TRICARE standard. Section H states the target healthcare cost also includes the PRIME enrollees with an MTF PCM.

a. Don't these two contradict each other?

RESPONSE: While Attachment L-1 is intended as broad brush summary of the solicitation and is provided for information only, we will revise the attachment.

b. With these statements in mind, is it the intent of the Government that the MCSC should include the PRIME enrollees with an MTF PCM in the target healthcare cost

even though these beneficiaries' purchased care dollars are under the control of the local MTF? (Section H.5.b.)

RESPONSE: It is the Government's intent that the purchased care for Prime enrollees with an MTF PCM be included in the Target Health Care Cost.

424. Section C-7.6 states "…Customer Services shall be delivered in a manner that achieves the objectives of this contract without charge to beneficiaries or providers." Please clarify the Government's intent for the contractor to provide without charge, Customer Services accessible services that may result in charges not under the control of the contractor. For example, cost incurred to send a fax to the contractor using the services of commercial enterprise.

RESPONSE: The contractor shall not design a customer service system in which the contractor charges the customer for its use. In your example, the contractor may not charge a fee to the customer for the contractor to receive and process a response to the fax. However, the beneficiary who choose to submit a document, for example, by fax using a commercial company who charges the beneficiary, the beneficiary's expense of that fax need not be reimbursed by the contractor.

425. Section C-7.7 states "…The contractor's medical management program must fully support the services available within the MTF." Please provide a description for each of the MTF services which the contractor is required to support.

RESPONSE: After reviewing the RFP and the data package, the contractor shall make the determination of how best to meet the requirements to support the MTF Services with its medical management program. The support will vary based on MTF capabilities and programs but may include; case management coordination, utilization management, and disease management information based on civilian sector care utilization. As stated in C-7.7.1, the contractors medical management program proposal is submitted for review and approval prior to implementation and annually thereafter.

426. Section C-7.26 states "The Government intends to establish a presence at the Prime contractor location and at each major subcontractor location." Please define the criteria for determining if a subcontractor qualifies as a "major" subcontractor.

RESPONSE: Please see the responses to Questions 208, 209, and 396. The term "major" will be changed to "first tier" in an amendment.

427. Section C-7.36.3 states "The contractor shall ensure that all electronic transactions, for which a standard has been named, comply with HIPAA…." Please clarify which standards the Government is referring to.

RESPONSE: Please see the TOM, Chapter 21 for the current HIPAA standards for electronic transactions.

428. Section C-7.37 requires the contractor to "…furnish the DoD TRICARE Operations Center and all Health Benefits Advisors… access to claims data." Please provide the quantity of users anticipated to be given access pursuant to this requirement.

RESPONSE: The number of personnel in the DoD TRICARE Operations Center needing access is approximately 10. The current list of Health Benefits Advisors and Beneficiary Counseling and Assistance Coordinators provided on the TMA web site would be one method for the contractor to estimate the activity to meet this requirement.

429. Section C-7.37 states "The contractor shall provide training and ongoing customer support for this access." What is the frequency of training anticipated by the Government?

RESPONSE: The contractor is expected to provide all and any training needed. The contractor will propose and the Government will evaluate the offeror's methods for fulfilling this requirement. Staff assignments for military individuals are generally of a 3 year duration.

a. Additionally, RFP section C-7.21.2 page 28 states: "The contractor shall provide data at the beneficiary, non-institutional and institutional level, with the intent of providing the Government with access to the contractors' full set of data associated with TRICARE." Please provide a description of the entities that will require access.

RESPONSE: Please refer to RFP Sections C-37 and C-37.1

b. Is the contractor responsible for providing the Government the hardware platform to access this data?

RESPONSE: No

430. Section C-7.9 This section states "The contractor shall meet with and establish a Memorandum of Understanding with the Marketing and Education contractor in accordance with TRICARE Operations Manual Chapter 16, Section 1 specifying the frequency, type and content of information the contractor shall provide the Marketing and Education contractor." Chapter 16, Section 1 of the TRICARE Operations Manual is titled "Coordination Procedures to Ensure Balanced Workloads." This section does not address Marketing and Education. Should the correct reference be Chapter 12, Section 1? Based on Chapter 12, Section 1, is it correct to assume the Government's intent is for all marketing and education materials, including newsletters and bulletins, to be furnished by the Marketing and Education contractor to the MCS contractor for distribution by the MCS contractor?

RESPONSE: Amendment 0001 corrected the reference to Chapter 12, Section 1. It is the Government's requirement that all marketing and education materials, including newsletters and bulletins, to be furnished by the Marketing and Education contractor to the MCS contractor for distribution by the MCS contractor.

431. Section C-7.1.12 - Ensure all network providers and support staff gain sufficient understanding of applicable program requirements…using education materials provided by the Marketing and Education Contractor.

a. We have reviewed the draft of the Marketing and Communications National Contract RFP, and need clarification as it relates to ensuring sufficient provider understanding of program requirements under the TRICARE health care RFP. For regional materials that are developed independently with specific content by the health care contractor, such as network, MTF and non-network provider manuals

which contain the specific claims processing and medical management information that will vary by region, will the National Marketing and Education Contractor provide a template to the health care contractor to independently develop these regional materials?

RESPONSE: Designated marketing and education products will be produced in template form and may be printed with or without the inclusion of local or service specific information to be disseminated by service SGs, Regional Directors, MTFs and other TRICARE contractors (to include the MCSCs) on as needed basis. However, the development of marketing and education materials falls under the responsibility of the future Marketing and Education Contractor.

b. Will the Marketing and Education contractor or the Government provide templates for MTF site specific beneficiary marketing brochures that will be developed by the health care contractor to promote specific MTF utilization?

RESPONSE: The MCSCs will not be developing that material.

432. RFP Section H.5.e - Allowable Health Care Cost and Payment - "In reference to FAR 52.216-4 (h)(2), the Contracting Officer will not approve contractor's expense to secure refunds, rebates, credits or other amounts as allowable costs."

Background: Occasionally overpayments are made which escape the usual post payment review and scrutiny. These overpayments appear as credit balances in the books of the hospitals which provide services to our beneficiaries. Many of these overpayments occur because two insurers pay as primary due to unreported Other Health Insurance, and can remain 'hidden', or unrecovered because neither insurer knows of the overpayment, and hospitals generally do not have the staff needed to adequately perform the research and analysis needed to determine the cause of the overpayment, or to identify which insurer should receive the refund. Even if hospitals would let representatives of specific insurers have access to their credit balance files, is it not economically plausible for any insurer, including TRICARE, to supply the staff needed to perform ongoing credit balance reviews in the hospitals.

As a result, many hospitals work with independent organizations whose sole business is claims recovery. At no cost to the hospitals, these companies do the analysis needed to identify the insurers who should receive the refund then contract with those insurers to recover any overpayments, net of commission. Even though insurers do not recover 100% of their overpayment, what is recovered could be considered 'found money' since it is possible that, absent this arrangement, nothing would have been identified or recovered. With the 80/20 cost share anticipated in the RFP, it may not be financially viable to pay these commissions out of administrative costs for even at-risk claims.

a. For at-risk claims, is it acceptable to record credit balance recoveries as recoupments net of commission rather than charging the recoupment fee to administrative expense, as long as other recoupment fees are charged to administrative expense?

Revised 8 October, 2002

RESPONSE: No. The full amount which is collected from the provider or beneficiary to whom the payment was originally made should be recorded against the receivable

that was originally created and show that the debt was paid completely. The allowable health care cost is to be net of health care cost recoveries and is not to include any administrative cost whether paid as a commission arrangement or through any other mechanism. All administrative expenses, regardless of the methods by which the amount is determined, are not allowable as health care costs.

b. Can the same practice be applied to credit balance recoveries for not-at-risk claims?

RESPONSE: No. Commissions paid for recovery of incorrect payments are not allowable as health care costs.

433. L-12.f.(2)(a) "The offeror shall submit information on experience **and** (emphasis added) past performance ....."

In this introductory statement to Past Performance submission requirements, it appears that the government is acknowledging that there is a distinction between experience and performance. Experience being activity or practice through which knowledge is gained, and performance being the results that were actually accomplished. However, in the remainder of the Past Performance submission requirements, the terms seem to be used interchangeably. Please clarify the government's intent with regard to the use of these terms. For instance, paragraph (b) of this section states: "The Government will only consider experience gained within the last three years. All (emphasis added) relevant experience shall be submitted. The offeror may submit any experience it believes demonstrates to the Government the capability of the prime and subcontractors to perform the required administrative services."

RESPONSE *Revised 30 December 2002*

RESPONSE: The referenced language was revised in Amendment 0006 to specify "past performance" as opposed to "experience and past performance".

a. Is the experience discussion to be limited to three years, or is only performance information limited to three years?

RESPONSE *Revised 30 December 2002*

RESPONSE: For the purposes of Section L-14f.(2)(b), the Government is asking for the offeror's past performance for the last 3 years. Sections L-14f.(2)(d), (e) and (f) requires Attachment L-4 to be completed by current accounts on the offeror's past performance and Section L-14f.(2)(g) requires Attachment L-5 to be completed by accounts terminated in the past 36 months on the offeror's past performance, For the purposes of Section L-14f.(2)(i), the Government is asking for reports on the offeror's past performance for the last 2 years.

434. L-12.f. (2) (b) - With regard to submitting supporting documentation, please clarify the following:

a. Does documentation need to be submitted electronically?

b. Is there any limitation as to the volume of supporting documentation that can be submitted?

c. Is there any restriction as to the types of information that can be submitted?

RESPONSE: Re 435a, b. and c. The requirement for supporting documentation was removed in Amendment 0001. The 25 page limit remains.

d. What is meant by "Relationship of the experience to the appropriate customer?"

RESPONSE: Tie the description of the experience to the appropriate customer/account.

435. L-12.f. (2) (d) page 87 – Past Performance Report

a. The requirement states, "The offeror and each of the first tier subcontractors shall submit a past performance report for each of their current top five overall accounts …" Is this past performance report Attachment L-4?

RESPONSE: Yes.

b. If so, we suggest the requirement read as follows: "The offeror and each of the first tier subcontractors shall submit a past performance report as specified in Attachment L-4 for each of their current top five overall accounts …"

RESPONSE: ***revised 20 September 2002***

RESPONSE: This will be clarified in a future amendment.

c. Does the Past Performance Report need to be submitted electronically?

RESPONSE: Yes. All documents, including those requiring signatures will be submitted electronically.

436. L-12.f. (2) (g) page 88 - Confirm the contact information form at Attachment L-5 is to be used in lieu of Attachment L-4 (Past Performance Report). Also, does the contact information form(s) need to be submitted electronically?

RESPONSE: Please use Attachment L-5, as corrected in Amendment 0001. All information is to be submitted electronically.

437. L-12.f. (2) (h) page 88 - Information on Key Personnel - With respect to the requirement to submit information on key personnel, confirm that Attachment L-6 is to be used for this purpose. Also, is there any limitation to the number of key personnel we identify and does the information on key personnel need to be submitted electronically? Finally, this paragraph indicates "Offerors are advised that TMA may contact none, any, or all references on the forms and may contact other third parties as determined necessary." Since Attachment L-6 does not contain a heading for references, clarification is required.

RESPONSE: ***revised 20 September 2002***

RESPONSE: Offerors are to use Attachment L-6 and will be clarified in a future amendment. There is no limit on the number of key personnel to identify and all experience and past performance information is required to be submitted

electronically. The reference is to forms and refers to all forms provided, not just Attachment L-6. No references are required on Attachment L-6 but may be provided.

438. In question #4 of the Q&As posted 8 August, 2002, you indicate that the offering of programs such as Stress Management, Couples Communication, Reunion Issues, etc—are services which "will not be required in the Managed Care contracts although an offeror could include these types of programs as a possible enhancement to their proposal." Are you saying that an offeror may propose benefits which are above and beyond those currently authorized in the TRICARE program?

RESPONSE: The discussion concerns programs not the addition of medical benefits outside of the TRICARE benefit structure. The contractor may propose any programs not required that assists the contractor in meeting the requirements of the contract. Such programs would be funded by administrative dollars.

439. TRICARE Operations Manual 6010.51-M, August 1, 2002, Chapter 12, Section 1, paragraph 1.1, states "The Marketing and Education contractor (MKEC) will provide a marketing and education program that informs and educates MHS beneficiaries, TRICARE and MHS staff and providers on all aspects of TRICARE programs." Chapter 12, Section 2, paragraph 2.0, states "All beneficiary education materials, including written materials, briefings, and other methods of publicizing the program, as well as the identification of the media to be used, shall be submitted through the appropriate Regional Director to the Contracting Officer for approval. The contractor shall provide representation at four MCS contractor conferences (senior management level) at TMA, annually. The costs for attendance at these meetings are included in the MCS contractor's cost for Administrative Support Services." The Section 2 paragraph implies that the MCS contractor is somehow responsible for obtaining approval for beneficiary educational materials. Please clarify.

RESPONSE: Chapter 12, Section 2, paragraph 2.0 does not apply to this solicitation and will be removed in a future change to the manual.

440. TRICARE Operations Manual 6010.51-M, August 1, 2002, Chapter 15, Section 3, paragraph 9.0, states the contractor shall submit a monthly Medical Management Report which "shall include:

Number of patients, by prime service area, in the medical management program, by medical management program component (e.g., case management, disease management, high cost, etc., based on the contractor's proposal)." Appendix A of the Operations Manual defines Medical Management as follows: "Contemporary practices in areas such as network management, utilization management, case management, care coordination, disease management, and the various additional terms and models for managing the clinical and social needs of the beneficiary to achieve the short and long term cost-effectiveness of the MHS while achieving the highest level of satisfaction among MHS beneficiaries." Network management is defined as a component of Medical Management. Please provide an example of how patients would be reported only in the network management program.

RESPONSE: Example (not to be considered as specific activity that the Government is mandating): The contractor profiles its providers and determines that, due to the

utilization patterns of a provider, the contractor no longer requires that specific specialist to receive an authorization to deliver a specific service that all other specialists require. Those patients that the provider self-authorizes would be reported.

441. I have a questing regarding an Aug. 1 DoD press release on the Tricare RFP announcement (http://www.defenselink.mil/news/Aug2002/b08012002_bt399-02.html). It states, "The solicitation will result in the award of three contracts covering the North, South and Western regions of the United States." Is there no contract to cover beneficiaries in the East, or does that region fall under another region's coverage area. Could you please explain.

RESPONSE: The entire eastern portion of the United States is included in the North and South contract regions.

442. Will Base Period CLINs 0002, 0003, 0601, 0602, 1101 and 1102 be awarded at the time of contract award or are they options which will be awarded sometime after contract award?

RESPONSE: Section B identifies these contract line items as part of the base period, not an option period. It is the Government's intent to initially award the base period for the West, North, and South contracts.

a. If those CLINs will be awarded at the time of contract award, can the contractor commence transition work upon contract award or does the contractor have to wait until the first date specified in each CLIN before starting transition work?

RESPONSE: The contractor may make its own management decisions; however, the Government will not begin paying for transition activities until the 10-month transition period begins.

443. Although the Base Period for the South contract is stated to commence on June 1, 2003, the CLINs for that task do not commence until October 1, 2003 for CLIN 0601 and January 1, 2004 for CLIN 0602. Please explain the discrepancy.

RESPONSE: The apparent discrepancy is due to different ending dates of current contracts in various areas. The transition period for each geographic area begins when the existing contract for that geographic area has expired. While a contract may be awarded, actual transition work may not begin for a particular portion of the area until sometime after initial contract award.

444. Although the Base Period for the North contract is stated to commence on June 1, 2003, the CLINs for that task do not commence until August 1, 2003 for CLIN 1101 and November 1, 2003 for CLIN 1102. Please explain the discrepancy.

RESPONSE: See response for #443

445. CLINs 0104, 0202, 0302, 0402, 0502, 0607, 0703, 0803, 0903, 1003, 1106, 1202, 1302, 1402, and 1502 are priced on a "per member per month" basis. Please define "member", describe how the quantity of members per month is determined, and identify the day of the month on which the quantity is determined.

RESPONSE: "Member" is defined as a MHS-eligible beneficiary. Section G, G-5, "Military Health System (MHS) Eligible Beneficiaries", describes how the quantity and when the members per month is determined.

446. The Transition Out CLINs are grouped under each Option Period for each contract. Are CLINs 0108, 0611 and 1110 intended to be for the transition out services to be performed if Option Period I of a contract is not exercised or are they intended to be for transition out services to be performed if Option Period II of a contract is not exercised?

RESPONSE: They are for the transition out only if option period II is not exercised.

a. Also, please provide the period of performance for each Transition Out CLIN. The schedules in Section F.5.d indicate the Transition Out services are required at least 210 calendar days after the end of health care delivery.

RESPONSE: Please refer to the TRICARE Operations Manual for the schedule of transition activities.

447. Are the estimated quantities for each Claims Processing CLIN based on the date of health care service, the date of receipt of the claim, the date the claim is processed to completion or some other basis?

RESPONSE: Date of receipt of the claim.

a. Are the costs for processing claims with dates of service prior to the start of health care delivery to be included in CLINs 0103, 0605 and 1105?

RESPONSE: For those non-network claims and adjustments that are transferred to the incoming contractor during the transition (TOM, Chapter 1, Section 8, paragraph 4.4.), the contractor will be paid the applicable claim rate for each of these claims.

448. Section B CLINs 0110AA, 0613AA, 1112AA. The government has provided health care experience data through Fiscal Year 2001. In the middle of FY 2001, change order P:21 eliminated most copayments for all ADFM Prime members. What are the government's estimates, by current contract region, of the impact on health care costs of this change order?

RESPONSE: Please see the response to Question 420.

449. Section B CLINs 0110AA, 0613AA, 1112AA. The government has provided health care experience data through Fiscal Year 2001. Option Period I of each contract begins in April 2004, with (apparently) different transition dates for health care for each current TRICARE region. Which significant health care change orders have been implemented since the beginning of FY 2001?

RESPONSE: Please refer to the TRICARE Web site (www.tricare.osd.mil.) Please go to the TRICARE Manuals section and you will find a list of changes. Also, please refer to Question 420.

a. What are the government's estimates, by area, of the health care cost impact of each of these change orders?

RESPONSE: Offerors are required to create their own estimates for bidding purposes.

b. Are there any significant change orders, by the government's estimation, that are not yet implemented, but will be implemented prior to or during Option Period I of the new contracts?

RESPONSE: The Government does not have knowledge of any outstanding significant change orders that are not public knowledge. Offerors are encouraged to review the TRICARE web site as well as recent and proposed legislation.

450. Section B CLINs 0110AA, 0613AA, 1112AA. The government has provided health care experience data through Fiscal Year 2001. Option Period I of each contract begins in April 2004, with (apparently) different transition dates for health care for each current TRICARE region. For each MTF in each region, what are the government-anticipated closures, partial closures, other significant MTF workload reductions, or MTF workload expansions, between the start of FY 2001 and the end of Option Period I?

RESPONSE: The available data has been provided with the data package available for purchase in support of this RFP.

451. Section B CLIN 0101. The RFP states "Transition Geographic Area 9/10/12 1 April 2004 – 30 June 2004". Does this mean that the winning offeror's health care responsibility (risk) for that geographic area does not begin until 1 July 2004? Same question for the South and North regions.

RESPONSE: The offeror's health care responsibility begins as follows:

Regions	Current Regions	Start of Health Care Dates
North	Region 2/5	June 1, 2004
	Regions 1	September 1, 2004
South (plus foreign, CHCBP)	Region 6	November 1, 2004
	Regions 3/4	August 1, 2004
West	Region 11	April 1, 2004
	Regions 9/10/12 (Alaska)	July 1, 2004
	Region Central	October 1, 2004

452. Section B CLIN 0110AB. For the proposed underwriting fee, the columns are labeled "Unit Price" and "Amount". For the Unit Price, should offerors propose a percentage?

RESPONSE: In the "unit price" column, offerors should propose a fixed-fee dollar amount. Section B of the RFP will be revised to allow for the Underwriting Fee percentage to be input in the Supplies/Services column under the line item description.
(e.g., 0308AB Underwriting Fee (Fee percentage - _____).

453. Section B CLIN 0110AB. For the dollar amount of the proposed underwriting fee, does the offeror need to provide a derivation of the amount? For example, the dollar amount could be the proposed fee percentage, multiplied by the estimated health care expenses for that period. In this example, would the offeror need to justify (in any way) the estimate of the health care expenses used in determining the underwriting fee dollar amount?

RESPONSE: The offeror does not need to provide a derivation of the fixed underwriting fee amounts proposed nor does the offeror need to provide justification of any estimated health care cost base that might have been used to calculate the underwriting fee amount. The Government expects consistency between the proposed fee percentage and the proposed fee amount.

454. Section B CLIN 0110AB. Section M states that the government will evaluate the underwriting fee amounts "for reasonableness". What criteria will the government use to determine whether a fee amount is reasonable? Will the government be looking for consistency between the fee percentage and the fee amount?

RESPONSE: The fee percentages and the fixed dollar amounts will be evaluated for reasonableness. Only the fixed-dollar underwriting fees will be included in the probable cost for Option Period I or the total evaluated price. The underwriting fee percentages will be determined unreasonable and unallowable if the fee percentages that are proposed are greater than 10 percent of target health care costs. The Government expects consistency between the proposed fee percentage and the proposed fee amount.

455. In Section C-2.1 on Page 23, Objective 2 uses the term "world-class health care". The term is also used in Section C-7.24.1. Please define that term and identify an analogous system. Also, please describe the difference between "world-class health care" and the term "best value health care" which is used in Objective 3.

RESPONSE: While a term of art, world-class health care means the delivery of health care and associated services that meet the highest standards. The TRICARE Operations Manual, Addendum A, defines best value health care as "the delivery of high quality clinical and other related services in the most economical manner for the MHS that optimizes the direct care system while delivering the highest level of customer service."

456. Sections C-7.1.6 and C-7.1.6.1 on Page 24 require the contractor to take certain actions in regards to "potential" network providers. Should these requirements only apply to actual network providers and not potential providers?

RESPONSE: No, we expect these actions to occur during the negotiation process with potential network providers.

457. RFP Section C-7.20.2, page 28, states "…for all MHS beneficiaries seeking information and/or assistance with urgent or emergent care situations. This function shall be accomplished with live telephone personnel only." Please clarify whether the twenty-four/seven accessible phone service with live telephone personnel is meant to apply only to urgent or emergent care situations and not any other types of general information or assistance requests from a beneficiary. Is it acceptable for Voice Recognition Unit (VRU) to be used to determine the nature of the call and once determined the call is from a beneficiary and is related to urgent or emergent care that it is referred to live telephone personnel? Or is it the intent of the government that a special beneficiary line for emergent or urgent care be established?

RESPONSE: Please see Amendment 0001 for clarification on the requirements. A VRU is not acceptable in fulfilling this requirement.

458. Section C-7.8 on page 27 states that the contractor shall receive self help books from the Marketing and Education Contractor. Please specify the dates by which is Marketing and Education Contractor is required to deliver the materials to the MCS contractor. Are there any other materials that the Marketing and Education Contractor is required to deliver to the MCS contractor? If so, what are the delivery dates for those other materials? Will the MCS contractor be charged for any materials that are provided by the Marketing and Education Contractor? If so, please identify the specific costs.

RESPONSE Revised 12 November 2002

RESPONSE: The requirement for the contractor to distribute the self help books will be deleted from the RFP in a future amendment. Self help books will be distributed by the government. In addition, the TOM, Chapter 12, Section 1, will amended in a future change. The MOU will be established between the MCS contractor and TMA, Communications and Customer Service Directorate (C&CS) to include material delivery methods and dates. The MCS contractor may request any types of materials it deems necessary for the region and will have representation on the Marketing and Education Committee to provide input as to the types of materials being developed. MCS contractors will not be charged for the materials.

459. Section C-7.38., page 32 What are the "optimum enrollment mix and numbers in the MTFs," and how will the contractor be made aware of the Government's specific goals for them? Also, will there be targets for each MTF or in aggregate?

RESPONSE: This will be determined by each MTF Commander and addressed in the MOU (See the TOM, Chapter 16, Addendum A) For a historical perspective, please review the data package.

460. Section C-7.42., page 33. Please define "the coverage usually provided under an outpatient pharmacy benefit," giving examples if possible. Exactly which pharmaceuticals will be the contractor's responsibility? Have these services been included in the Government's data tapes?

RESPONSE: Those would be services provided other than through a retail pharmacy or the TRICARE Mail Order Pharmacy. Examples are home heath infusions from a specialty pharmacy, take home drugs provided by the hospital, and injections given in a doctor's office where the physician supplies the injectable. All historical data available is in the purchased care detail tapes.

461. In Section F.3.a on Page 36, the phrase "If exercised,…" is used in reference to Option Periods II, III, IV and V but is not used for Option Period I. Is Option Period I subject to being exercised or is it awarded with the Base Period?

RESPONSE: Option period I will not be awarded initially and is subject to being exercised.

462. Section F.5.c on Pages 37, 38 and 39 refers to many reports that are to be delivered within a specific number of days prior to, or after, the start of health care delivery. Many of those reports do not seem to require multiple submissions but, since each region has two or three geographic areas that start health care delivery at different times, multiple deliveries are implied. Please clarify which reports are required to be submitted only once and which reports are specific to geographic areas within each region and have multiple deliveries based on the different dates for the start of health care delivery in each geographic area.

RESPONSE: There is no requirement for multiple reports based on the phase in times for the areas. For example, there is only one monthly enrollment report per MCS contract (TOM, Chapter 15, Section 3). Using the South contract as an example, the first enrollment report would be due at the start of health care delivery (August 1, 2004) covering the current Regions 3/4. When the start of health care delivery of current Region 6 (November 1, 2004) occurs, the one enrollment report will add that enrollment data to the report and then contain all 3 current region's enrollment activities.

463. Section F.5.c.(12) on Page 38 requires the Network Development Plan to be delivered "180 calendar days prior to the start of health care delivery and 90 days prior to the beginning of each option period." Since Option Period I for all three contracts starts on April 1, 2004, the Network Development Plan is due about January 1, 2004 for all three contracts. However, transition services for the Central geographic area commences only one month prior to the due date for the Network Development Plan for the West Contract and the transition services for geographic area 6 begins three months after the Network Development Plan is due for the South Contract. Please clarify when the Network Development Plan is due under each contract or clarify when transition services can commence under each contract.

RESPONSE: Section F.5.c.(12) will be amended to follow the TOM, Chapter 5 to require only a plan 180 days prior to the start of health care delivery.

464. Section F.5.c.(13) on Page 38 requires the Network Adequacy Reports to be delivered "30 calendar days after contract award and every 30 calendar days thereafter through the transition period and 6 months of the contract." Please clarify whether the report is required by region or by geographic area within the region. Also, please clarify whether the report is required for the entire transition period or for only the first six months of the transition period (i.e., the first 6 months of the contract).

RESPONSE: There is only one report monthly per contract and as current regions are transitioned in those areas will be included in the report. Section F.5.c.(12) will be amended to follow the TOM, Chapter 15 to require the report to be provided through the first 6 months of health care delivery. For example, for the South contract, the last report will cover April 2005.

465. Section F.5.c.(14) on Page 39 requires delivery of a report ordering TRICARE marketing and educational materials from the marketing and education contractor. Please identify what materials will be available besides those specified in Section C-7.8. Please clarify what is meant by the phrase "by the 90th calendar day for all subsequent contract periods".

RESPONSE Revised 12 November 2002

RESPONSE: Please refer to the TOM, Chapter 12, Section 1 and the Draft Marketing and Education RFP Section C (http://www.tricare.osd.mil/pmo/t-nex/marketing_education.cfm) for further details on the materials supplied by the Marketing and Education Contractor. The phrase means that the MCSC must order additional and new marketing and education materials annually 90 days prior to contract Option Periods 2-5, not produce a report. In a future amendment, the contractor will be directed to order the materials from the Government not the Marketing and Education Contractor.

466. Section F.5.c.(15) on Page 39 requires education and marketing materials to be distributed prior to the start of health care delivery but it does not require any subsequent distribution. Please clarify whether this is intended to be a one-time requirement and, if it is not, what is the subsequent distribution schedule.

RESPONSE: Section F only applies to start up activities. Please refer to the TOM, Chapter 12 for all distributions.

467. Section F.5.c.(16) on Page 39 requires TRICARE Service Center Operations to be "delivered" 40 calendar days prior to the start of health care delivery. When will the outgoing contractor be required to vacate the TRICARE Service Centers?

RESPONSE: That is negotiable between the two contractors; please see the TOM, Chapter 1, Section 8, paragraph 4.4.3.3. for the complete requirements.

a. Will there be a scheduled "down time" for the TRICARE Service Centers to do transition activities (e.g., move furniture and equipment out and in, change telephone and data lines, move personnel, etc.)?

RESPONSE: That is negotiable between the two contractors; please see the TOM, Chapter 1, Section 8, paragraph 4.4.3.3. for the complete requirements.

468. Section F.5.c.(17) on Page 39 requires the delivery of a "Public Notification Program". Please identify the Section C requirements pertaining to this deliverable report and specify what information is required in the report.

RESPONSE *REVISED 30 December 2002*

RESPONSE: This is not a report but a deliverable during start-up. Please refer to the TOM, Chapter 1, Section 8, paragraph 2.12 for the complete requirements.

469. Section F.5.c.(18) on Page 39 requires the delivery of "Web-based Services". Please identify the Section C requirements pertaining to this deliverable report and specify what information is required in the report. Since the delivery schedules do not coincide, is it correct that "Web-based Services" are not required to be delivered as part of Benchmark Testing pursuant to Section F.5.e?

RESPONSE *REVISED 30 December 2002*

RESPONSE: This is not a report but a deliverable during start-up. Please refer to the TOM, Chapter 1, Section 8, paragraph 2.13 for the requirements.

470. Section F.5.c.(20) on Page 39 requires the delivery of a Contingency Program. Please clarify what is meant by the term "by the 60th calendar day for all subsequent contract periods".

RESPONSE: This requirement is from Section C-7.30.1. The contractor will update its Contingency Program and provide it to the Regional Director sixty calendar days prior to the start of contract Option periods 2, 3, 4, and 5.

471. Section F.5.d on Pages 39 and 40 provides for Transition Out schedules. Should the offeror assume that the successor contract will be awarded during the final Option Period of the contracts resulting from this RFP (i.e., the Transition In period of the successor contract will not exceed 12 months)?

RESPONSE: Your assumption is correct.

472. Section F.5.d.(3) on Page 39 provides for the delivery of the Transition Out of the Duplicate Claims System in accordance with the transition schedule. Please specify the transition schedule or provide a copy of it.

RESPONSE: The Transition schedule is a document created during the Transitions Specifications Meeting with the incoming MCSC, outgoing MCSC, other contractors as needed, and the Government. Please see the TOM, Chapter 1, Section 8 titled "Transitions".

473. Section F.5.d.(4) on Pages 39 and 40 requires the delivery of Contractor File Specifications within 3 calendar days of contract award. Does the term "contract award" refer to the successor contract? How much notice will the contractor receive regarding the specific date by which this report must be delivered?

RESPONSE: Yes, it refers to the successor contract and the outgoing contractor will not be notified when the report will be due but will be notified of the award.

474. Section F.5.d.(6) on Page 40 requires the delivery of Provider Information at the direction of the Contracting Officer. How much notice will the contractor receive regarding the specific date by which this report must be delivered?

RESPONSE: Generally, this is negotiated at the Transition Specifications Meeting referenced above.

475. Section F.5.d.(7) on Page 40 requires the delivery of Weekly History Updates "until completed in accordance with the transition schedule". Please clarify the end date for this deliverable.

RESPONSE: Please refer to the TOM, Chapter 1, Section 8, Paragraph 4.3.4.

476. Section F.5.d.(9) on Page 40 requires the delivery of Non-ADP Files in accordance with the transition schedule. Please specify the transition schedule or provide a copy of it.

RESPONSE: The Transition schedule is a document created during the Transitions Specifications Meeting with the incoming MCSC, outgoing MCSC, other contractors as needed, and the Government. Please see the TOM, Chapter 1, Section 8 titled "Transitions".

477. Section G-3.a(3)(b) on Page 42 provides for payment of claims processing CLINs. Is the payment rate (i.e., the applicable CLIN) based on the date of health care service for the claim, the date that the claim was received, the date that the claim was paid, or the date on which the TED was accepted? Which claims processing CLIN applies for claims that are processed after Option Period V (i.e., during transition out)?

RESPONSE: Claims processing payments are based on TEDs being accepted provisionally or clearing all edits, whichever comes first, as stated in the Section G language. These edits are identified in the TEDS manual. Payments will be based on a claim rate times the number of claims clearing edits. The date used to determine applicable claim rate is the batch/voucher date submitted in the header. Assuming the contract extends through all 5 option periods, the claim rate for processing claims received after the start of health care delivery for services received before the start of health care delivery of the new contract will be the CLIN for Claims Processing in OP5.

478. Section G-3.a(3)(j) on Page 42 provides for payment of Transition Out services "following completion of work". Please clarify the scheduled completion date of Transition Out services by which payment can be expected by the contractor.

RESPONSE *Revised 13 December 2002*

RESPONSE: Transition out dates for separate requirements will be determined during the Transitions Specification meeting. This does not relate to transition out of the current contracts. Payments are normally made based on the Prompt Payment Act 30 day requirement.

479. Section G-4 on Page 44 indicates that the "Claims Processing" CLINs (CLIN 0103 etc) are ordered by delivery orders issued by TMA. What is the implementation period for each delivery order? Will delivery orders be issued for a term less than an Option Period? Will delivery orders be issued for a term of less than one month? Will delivery orders be issued for less than the expected number of 'Claims" for a month? How should the contractor determine whether the ordered number of "Claims" has been met but not exceeded? Does the contractor determine the number of claims ordered by a delivery order based on the number of claims received, the number of claims processed, the number of claims paid, the number of claims for which a TED was accepted or some other method? When the number of claims ordered is met, how does the contractor handle subsequent claims that are received (return or reject) or claims that are in process?

RESPONSE *Revised 13 December 2002*

RESPONSE: Each delivery order will specify the period of performance, the number of claims ordered, the claim rate, the extended delivery order price, and amount obligated.
As to the status of the delivery orders - the contractor should have a record of claims processed and submitted to TMA, under what delivery order and the claim rate. Payments will be made only for accepted TEDs records. Contractors should have an appropriate system to track these transactions.
For additional details not directly addressed in this response, we suggest that potential offerors review the clauses 52.216-18, Ordering, and 52.216-21, Requirements, in the solicitation. Any additional details are best addressed in a post award conference between the Government and the successful offerors. Since any additional details are regarding contract administration and do not impact a potential offeror's proposal, we suggest a successful offeror ask detailed questions at the post award conference.

480. Section G-4 on Page 44 indicates that the "Per Member Per Month" CLINs (CLIN 0104 etc.) are ordered by delivery orders issued by TMA. Please define the term "Member", describe how the quantity of "Members per Month" is determined, and identify the day of the month on which the quantity is determined. What is the implementation period for each delivery order? Will delivery orders be issued for a term less than an Option Period? Will delivery orders be issued for a term of less than one month? Will delivery orders be issued for less than the expected number of "Members" for a month? How should the contractor determine whether the ordered number of "Members" has been met but not exceeded? When the number of "Members" during a particular month ordered is met, how does the contractor handle subsequent requests for services from additional "Members" or TRICARE eligibles that are requested for that month?

RESPONSE *Revised 13 December 2002*

RESPONSE: Section B, paragraph G-5 of Section G, paragraph L-14(4)(h)[5] and Attachment L-8 of Section L defines Per Member Per Month (MHS eligible beneficiaries) and describe how and when the quantity of Per Member Per Month is determined. Also see response to 445.
Regarding the general questions about delivery orders, see the response to the preceding question (479).

481. Section G-3b1, page 43. What is the meaning of "revised financing" under this procurement?

RESPONSE: Revised Financing refers to the arrangement where the contractor bills and is reimbursed by the MTF for care provided in the civilian sector for MTF Prime enrolled beneficiaries

482. Section G 5, page 44. Which six of the "seven previous months of eligible beneficiaries" will be used in computing the average? Why would the six months within the period of interest not be used? Also, how can the contractor address any errors in the Government counts? Will the contractor be provided copies of the monthly DMDC "STST II REPORT"? Will the number of MHS eligible beneficiaries be retrospectively corrected to adjust for actual counts in an Option Period?

RESPONSE: The seven month period is necessary to allow the Government one month to obtain the data and compute the average. For instance, it the period in question is January through June, the Government will apply the average of May through November (6 of the last 7 months) to the period. DEERS is the data source of record, but if the contractor is aware of errors it should bring that to the attention of the Contracting Officer. If the contractor requests a copy of the report from the Contracting Officer, a copy can be provided. No, there will be no retroactive adjustment.

483. Section H-4.b on Page 47 provides that "Any allowable resource-sharing expenditure will be reimbursed…" Please identify the CLINs under which the resource sharing expenditures will be reimbursed since, pursuant to Section L.14, the contractor is directed to not include resource sharing savings in CLINs 0110, 0613 and 1112.

RESPONSE: Any allowable resource sharing health care expenditure will be reimbursed under the health care CLIN for the appropriate time period. Resource sharing administrative costs will be paid as part of the appropriate administrative price CLIN if they have been included in the bid amount for that CLIN. The instruction in L.14 is for preparation of the offeror's price only and refers to savings, not to expenditures.

484. Section H-5.e on Page 48 provides that "the Contracting Officer will not approve contractor's expense to secure refunds, credits, or other amounts, as allowable costs." Does this provision mean, for example, that, if a Change Order is issued to retroactively reduce reimbursement rates, the expenses to secure refunds will not be recognized as an allowable expense under the Change Order?

RESPONSE: Paragraph H-5 and FAR 52.216-7 is only applicable to the cost-reimbursable part of the RFP, with exception to the case management/disease management line items as stated in H-5a. This only means that such costs are not, and will not be, allowable costs only under the health care line items, which are cost-reimbursable line items. Since this type of effort is not underwritten health care costs, it is considered an administrative cost. Thus, the Contracting Officer may recognize it as an allowable administrative cost under a change order.

485. RFP Section H.8.e, page 49 Telephone Service (Total Hold Time)
The RFP places a priority on improved and specialized customer service for beneficiaries. Is it the government's intent that this standard be applied only to

beneficiary calls? For purposes of measuring contractor performance of the standard, does the call start once contractor live personnel begin handling the inquiry

RESPONSE: The standard applies to all calls. Total on hold time shall not exceed 30 seconds during the entire phone call. Please refer to the TOM, Chapter 1, Section 3 for all standards and to paragraph 3.4. for specific telephone standards

486. If an Option Period is exercised pursuant to Section I.106 on Page 69, Option To Extend The Term Of The Contract, are all CLINs in Section B under that particular Option Period thereby exercised and effective? For example, when Option Period I of the West Contract is exercised, are CLINs 0101 through 0110 thereby exercised? If so, what are the contractor's obligations under CLIN 0108?

RESPONSE: If an option period is exercised, it includes the contract line item numbers under that option.

487. Section I.106(c) on Page 69 states that "The total duration of this contract, including the exercise of any options under this clause, shall not exceed 5 years and 10 months." That period corresponds to the Basic Period and all five Option Periods; however, it does not include any performance time required by Section I.105 on Page 69 and any performance time for Transition Out activities such as those required in Sections F.5.d.(10), (11) and (13).

RESPONSE: The performance period, if FAR clause 52.217-8, OPTION TO EXTEND SERVICES (NOV 1999) were invoked, is not part of the anticipated contract performance period.

488. Section I.108 on Page 69 and 70 contains provisions that are left blank. Please provide the missing information for subparagraphs (a) and (i).

RESPONSE: The fill-in data for this clause will be forthcoming in a future amendment.

489. Section I.109 on Page 70 is not appropriate for this contract since, in accordance with FAR 37.401, the clause at FAR 52.237-7 is only required for nonpersonal service contracts between the government and physicians, dentists and other health care providers. If Section I.109 is not deleted, it contains a provision in subparagraph (a) that is left blank. Please provide the missing information.

RESPONSE: This will be a non-personal services contract, so the clause does apply. The missing information will be added by an amendment to the RFP.

490. Section I.110 on Page 71 states that there are deviations from the FAR and from DFARS. Please provide all documentation (including but not limited to Determinations and Findings and Justifications and Authorizations) that support and justify the request and approval of deviations from the FAR and DFARS.

RESPONSE: ***revised 22 October 2002***

The document was posted 22 October 2002.

491. Section L.10.e on Page 80 requires delivery of the proposals to an address that is different than the address specified in Section A (Block 9 of the Standard Form 33,

which refers to Block 8, which refers to Block 7). What is the correct address for delivery of the proposal?

RESPONSE: While both zip codes are correct as TMA-Aurora "owns" both of them, please use zip code 80011-9043. Section L10e. will be changed.

492. Section L.10.i on Pages 80 and 81 states that "The Government will base its evaluation solely on the information presented." However, Section M.7.a states that "Past performance will be evaluated utilizing the information obtained from past performance documentation furnished with the proposal and information obtained from other sources." Please reconcile the conflict between those RFP Sections and explain whether the proposal evaluation will be based solely on information presented by the contractor or whether it will be based on information obtained from other sources. If the evaluation is to be based on information obtained from other sources, what other sources are used to obtain the information?

RESPONSE: The Government will base its evaluation solely on the information presented, except for past performance. We intend to clarify the language in an Amendment to the RFP. The Government will consider all information provided by the offerors, and past performance information obtained from other sources when evaluating the offeror's past performance. See FAR Part 15, specifically Subpart 15.305 for details.

493. Section L.12.f.(2)(b) on Page 87 provides that "The Government will only consider experience gained within the last three years". That sentence appears to conflict with the two sentences that follow it which state that all relevant experience shall be submitted and "The offeror may submit any experience it believes demonstrates to the Government the capability of the prime and subcontractors to perform the required administrative services." Please clarify whether the past performance narrative and all other past performance information submitted by the offeror is restricted to the last three years. Section M.7.b on Page 94 states that "The Government will evaluate past performance as it relates to fulfilling the functional requirements of all elements in Section C". Please clarify whether (and how) the government will evaluate past experience and performance for Transition In services (a Section C requirement), since similar transition-in services under all seven current MCS contracts were completed more than four years ago and the Government will only consider experience gained within the last three years.

RESPONSE: For Sections L-12f.(2)(b) and (c) the Government will only consider experience gained within the last three years. (The last 3 years is defined as: 3 years as of 60 calendar days prior to the proposal due date.) For Sections L-12f.(2)(d), (e), and (f) the current accounts questionnaire (Attachment L-4) and any accompanying narrative should follow the principal of recent, relevance past performance. For Section L-12f.(2)(g), submit Attachment L-5 for terminated or no renewed accounts within the last 36 months. For Sections L-12f.(2)(h), the offeror shall "address specific information on qualifications, experience, and demonstrated performance relevant to their proposed positions, including individual leadership qualities" and there is no time limits. For Sections L-12f.(2)(i), provide final reports that cover 2 years prior to the submission of the past performance information.

494. Section L.12.f.(2)(h) on Page 88 requires the offeror to submit information on key personnel addressing their qualifications, experience and demonstrated performance relevant to their proposed positions. Is the proposal information, that

is required to be submitted on key personnel, subject to the restriction in Section L.12.f.(2)(b) on Page 87 that "The Government will only consider experience gained within the last three years"? If so, are professional education, degrees and credentials that were achieved more than three years ago not considered by the Government in the proposal evaluation? Also, is someone with significantly more than three years experience rated equal to someone with only three years experience because only the last three years are considered?

RESPONSE: Section L.12f(2)(h) has no time limits; see prior answer above.

495. Section L.12.f.(3)(a) on Page 88 requires offerors to provide financial information "on any prior or prospective significant merger candidates". Since every company in the industry could be considered a prospective merger candidate, what is a "prospective significant merger candidate"? What periods of time are covered by the words "prior or prospective"?

RESPONSE: The information requested in L.12.f.(3) is for the Contracting Officer to utilize in making a responsible contractor determination. Offerors are expected to use their own reasonable judgement regarding disclosure based on the guidelines in FAR 9.1 and their own unique situations.

496. L.12.a Proposal Preparation, page 81, states "The proposal shall consist of …." Several of these items (SF 33, Section K) are generally considered part of the Cost Proposal. This RFP section does not correlate to sections L.12.c, either the list of "separate entities" or the paragraph on the Technical Proposal or L.12.f.(1) Technical Proposal/Oral Presentation Slides or L.12.f.(4) The Cost Proposal. Please clarify the relationship of these sections and what is expected to be submitted to the government.

RESPONSE: Offerors are expected to submit everything listed in the referenced paragraphs. These paragraphs will be clarified in an amendment to the RFP.

497. L.12.f.(4)(i), page 89, has sub-items starting with (2). Is there a sub-item (1) missing? Should L.12.f.(4)(I) be L.12.f.(4)(h)(1)? Please Clarify

RESPONSE: The numbering error has been corrected in Amendment 0001.

498. L.12.f.(4)(i)(6)(g) Health Care Prices, page 90 seems to be out of outline sequence. Should it be L.12.g or should it be L.12.f.(4)(i)? Please clarify.

RESPONSE: The numbering error has been corrected in Amendment 0001.

499. L.12.d.(11), Oral Presentation Schedule, page 83, has Offeror's Presentation from 8:00 a.m.-12:45 a.m. We assume this should be 12:45 p.m. Please confirm.

RESPONSE: That's correct; this error was corrected with Amendment 1.

500. Attachment L-1, page 3, second paragraph states " … the contractor will receive telephone call that are directly and automatically referred to the contractor by the Government's TRICARE Call Center." Does the government envision this to be a three-way call with the caller, TRICARE Call Center rep, and the contractor rep, or a "hot-transfer" from the TRICARE Call Center rep to the contractor rep? What technology is in place at the TRICARE Call Center for this purpose?

RESPONSE: Generally, the call will either be automated or a person to person call from the call center to the contractor. Only rarely will the contractor stay on the line after the transfer. We cannot respond as to the technology because it is anticipated that technology will be changed.